

# APPLICATION FOR DENTAL HYGIENE LICENSURE COMING FROM ANOTHER STATE

## MARYLAND STATE BOARD OF DENTISTRY

A Division of the Maryland Department of Health

55 Wade Avenue, Benjamin Rush Bldg.

Catonsville, Maryland 21228

[www.health.maryland.gov/dental](http://www.health.maryland.gov/dental)

Please read the instructions carefully and be familiar with the laws and regulations governing the practice of dental hygiene in the State of Maryland. Visit the following website for more information: [www.health.maryland.gov/dental](http://www.health.maryland.gov/dental).

### **\*\*IMPORTANT\*\***

The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed.

Please review this application before you submit it to ensure that all information and documentation is complete and correct.

Incomplete applications are maintained in the Board office for a period of thirty (30) days. After such time the application is rendered void, returned and will be subject to a \$50.00 application reprocessing fee. The applicant must re-apply and pay all required fees.

### **Application Checklist**

The following checklist is an important part of your application.

Please use this checklist to ensure that you submit a COMPLETE application.

The total application fee of **\$325.00** (Jurisprudence Exam fee included) payable by check or money order to the Maryland Board of Dental Examiners must be included with your application.

1. **NOTARIZED APPLICATION: Completed application form** accompanied by the NON-REFUNDABLE APPLICATIONS FEE of (\$275.00). Your application will not be processed unless the fee and all supporting documents are received. The licensure process could take up to a minimum of **4 weeks** after submission of a completed application. Plan your application time accordingly.
2. **NOTARIZED PHOTOGRAPH:** The photo must meet the following guidelines: taken within the last 2 years to reflect your current appearance; front view of full face from top of hair to shoulders; a natural expression; no hat or head covering that obscures the hair or hairline, unless worn daily for religious purposes; no sunglasses, headphones, wireless hands-free devices or similar items; no other individuals or distractions in the photo. Photos copied or digitally scanned from driver's licenses or other official documents are not acceptable. In addition, low quality vending machine or mobile phone photos are not acceptable. "Passport" photos are acceptable. Unacceptable photos will be returned and may delay the issuance of your license.
3. **PROOF OF EMPLOYMENT:** Notarized statement attesting to the fact that you have been actively practicing dental hygiene for at least 3 years, and you have been actively engaged in practicing dental hygiene for at least 150 hours on average per year for a total of at least 450 hours. This statement must include the dates of practice, hours practiced, and location of practice. **If you are a recent graduate and have not worked a total of 450 hours in another state, you are exempt from this using this application.**
4. **LICENSE VERIFICATION: Official licensure verification** for every dental hygiene license ever held. Each verification must indicate the date of licensure, the licensure status (active, inactive, non-renewed, probation, etc.), any disciplinary actions taken against you by the licensing board and the result of these actions under Health Occupations Article, §4-315, Annotated Code of Maryland. The applicant must provide a certified copy of the formal complaint/pleading, outcomes, and a personal written explanation for each instance of discipline. You should call each state board about fees for these services. The verification must be submitted with your application IN THE ORIGINAL SEALED ENVELOPE FROM THE STATE BOARD, and must be dated within 6 months of Board receipt of your complete application packet.

5. **DEGREE TRANSCRIPT OR LETTER:** An official transcript or letter which documents graduation with an A.S., A.S.S., B.A., B.S., or CERT. degree from a dental hygiene school which is accredited by the American Dental Association (ADA) Commission on Dental Education. The transcript/letter must be IN THE ORIGINAL SEALED ENVELOPE FROM THE COLLEGE. Maryland laws §§ 44.22.10 require graduation from an ADA-accredited school.
6. **NATIONAL BOARD SCORES:** National Board Dental Hygiene Examination Scores (NBDHE) from the ADA Joint Commission on National Dental Examinations. The ADA will no longer send results via mail. You may access your national board results online by going to [http://www.ada.org/~media/JCNDE/pdfs/nb\\_online\\_results.pdf?la=en](http://www.ada.org/~media/JCNDE/pdfs/nb_online_results.pdf?la=en). Download your results and submit with your application or request the score to be released to the Maryland Board of Dental Examiners. Board will obtain the scores after you have made the request. If you have any issues accessing this information, please contact the ADA at 800-232-1694 or [nbexams@ada.org](mailto:nbexams@ada.org).
7. **CLINICAL LICENSURE EXAMINATION REPORT:** Evidence that you passed an examination with a clinical component as required for licensure in another state.
8. **COMPUTER SIMULATED CLINICAL EXAMINATION:** Examination report from Commissions on Dental Competency Assessments (CDCA) certifying that you passed the Computer Simulated Clinical Examination (CSCE).
9. **JURISPRUDENCE EXAMINATION:** Successful completion of the Jurisprudence Examination with a score of 75 or higher. The Jurisprudence Examination will follow the application and may be taken as an open book exam. The examination and "laws and regulation" governing the practice of dental hygiene in Maryland will also follow this application. The fee for the Jurisprudence Exam is \$50 which is included in the \$325 initial fee.
10. **COPY OF COURT DOCUMENT OR AFFIDAVIT** explaining any discrepancies of the applicant's name if documents submitted display different name(s). [i.e., marriage certificate, divorce decree, legal name change]
11. **EXPEDITED APPLICATION REVIEW:** Military spouses, service members and transitioning service members qualify for expedited application review.
12. **RELOCATION:** If you relocate during the time that your application is being processed, you must notify the Board of your new address in writing by fax 410-402-8505 or mail. This will enable you to receive Board correspondence. Should you relocate after receiving your license, you must notify the board within 60 days. A fine of \$10 will be assessed after 60 days.

# MARYLAND STATE BOARD OF DENTAL EXAMINERS

Spring Grove Hospital Center • Benjamin Rush Building • 55 Wade Avenue • Catonsville, Maryland 21228 • (410) 402-8510

## APPLICATION FOR DENTAL HYGIENE LICENSURE COMING FROM ANOTHER STATE

### Notice For Mailing List:

The information collected on this application form is collected for the purposes of the Board's functions under the Annotated Code of MD, Health Occupations Article, Title 4. Failure to provide the information may result in denial of your application. You have a right to inspect, amend, and request correction of this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law. Under the Maryland Public Information Act, Annotated Code of Maryland, General Provisions Article, §4-333, the Board may provide, for a fee, a list of licensees' names and addresses to professional associations and other entities. You may request in writing that your name be omitted from such lists.

### Information for Veterans, Service Members, and Military Spouses

Please note the following:

"Veteran" is a former service member who was discharged from active duty under circumstances other than dishonorable within 1 (one) year before the date on which this application has been submitted. "Veteran" does not include an individual who has completed active duty and has been discharged for more than 1 year before the application for a license, certificate, or permit is submitted.

"Service member" is an individual who is an active duty member of the armed forces of the United States, a reserve component of the armed forces of the United States, or the National Guard of any state.

"Military Spouse" is the spouse of a service member or veteran and includes the surviving spouse of a veteran, or a service member who died within 1 (one) year before the date on which the application for licensure is submitted to the Board.

Veterans, service members and military spouses are assigned an advisor to assist in the application process. In addition, the Board will expedite the processing of completed applications for veterans, service members, and military spouses. If you do not meet the education or training or experience requirements for licensure, your advisor will assist you in identifying programs that offer relevant education or training, or ways to obtain the necessary experience.

Your advisor is Sandra Sage. Ms. Sage may be reached at 410-402-8510. In Ms. Sage's absence you may contact Ms. Debbie Welch at 410-402-8511.

Are you a: **Veteran:** ☐ Yes ☐ No    **Service Member:** ☐ Yes ☐ No    **Military Spouse:** ☐ Yes ☐ No

### SECTION I – GENERAL INFORMATION

<b>Name (Last, First, Middle Initial):</b>	
<b>Address of Record: (Street Address)</b>	
<b>City, State, Zip:</b>	

**A. Social Security Number:** --  
(There is a statutory requirement that you disclose your social security number. It will be used for identification purposes only.)

**B. Date of Birth:** --

**C. Home Phone Number:** --

**D. Cell Phone Number:** --

**E. Work Phone Number:** --

**F. E-Mail Address:**

**G. Gender Identification:**

☐

Female

☐

Male

**H. Race/Ethnic Identification – Please check all that apply**

Are you of Hispanic or Latino origin? Yes ☐ No ☐

(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
2. ☐ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
3. ☐ Black or African American (A person having origins in any of the black racial groups of Africa.)
4. ☐ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
5. ☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

**I. Licensure in other states:**

List other states or jurisdictions in which you hold or have held a dental hygiene license.

State	License Number	Expiration Date

## **SECTION II - EDUCATION**

**A. School of Graduation (Name, City, State, Country):** \_\_\_\_\_

\_\_\_\_\_

**B. Date of Graduation:** \_\_\_\_\_ **Degree Earned:** \_\_\_\_\_

## **SECTION III – EXAMINATIONS**

**A.** Have you passed the National Board Examination(s)? ☐ Yes ☐ No

**B.** Date of examination: \_\_\_\_\_ Location of examination: \_\_\_\_\_

**C.** Have you passed all sections of the American Board of Dental Examiners (ADEX/NERB) examination? ☐ Yes ☐ No

**D.** Date of examination: \_\_\_\_\_ Location of examination: \_\_\_\_\_

**If you have passed either the North East Regional Board (NERB) or the American Dental Licensing Examination (ADHEX) more than 3 years prior to the date of this application, please attach a detailed work history with the application, including the full name, address, telephone number and dates of employment for each place employed.**

#### **SECTION IV - CHARACTER AND FITNESS**

**If you answer "YES" to any question(s) in Section IV – Character and Fitness, attach a separate page with a complete explanation of each occasion. Each attachment must have your name in print, signature, and date.**

**YES    NO**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Has any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal entity denied your application for licensure, reinstatement, or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or non-judicial punishment? If you are under a Board Order or were ever under a Board Order in a state other than Maryland you must enclose a certified legible copy of the entire Order with this application. |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Have any investigations or charges been brought against you or are any currently pending in any jurisdiction, including Maryland, by any licensing or disciplinary board or any federal or state entity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Has your application for a dental hygiene license in any jurisdiction been withdrawn for any reason?   |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system?   |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Have you had any denial of application for privileges, been denied for failure to renew your privileges, or limitation, restriction, suspension, revocation or loss of privileges in a hospital, related health care facility, or alternative health care system?  |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations?   |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Have you pled guilty, nolo contendere, had a conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?   |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Do you have criminal charges pending against you in any court of law, excluding minor traffic violations?  |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Do you have a physical condition that impairs your ability to practice dental hygiene?   |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Do you have a mental health condition that impairs your ability to practice dental hygiene?  |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Have the use of drugs and/or alcohol resulted in an impairment of your ability to practice dental hygiene?   |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Have you illegally used drugs?   |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal or state entity?  |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Have you been named as a defendant in a filing or settlement of a malpractice action?  |
| <input type="checkbox"/> | <input type="checkbox"/> | o. Has your employment been affected or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal entity for any disciplinary reasons or while under investigation for disciplinary reasons?   |

The Well Being Committee assists dental hygienists and their families who are experiencing personal problems. The Committee has helped numerous dental hygienists over the years with problems such as stress, drug dependence, alcoholism, depression, medical problems, infectious diseases, neurological disorders and other illnesses that cause impairment. For more information please call 800-974-0068 or visit the website at [www.mdhaweell-being.org](http://www.mdhaweell-being.org).

**Incomplete applications will be returned and will be subject to a \$50.00 application reprocessing fee.**

**Release and Certification:**

I hereby affirm that I have read and followed the above instructions. I hereby certify that all information in this application is accurate and correct.

I agree that the Maryland State Board of Dental Examiners (the Board) may request any information necessary to process my application for dental hygiene licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual dentists, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

I agree that I will fully cooperate with any request for information or with any investigation related to my dental hygiene practice as a licensed dental hygienist in the State of Maryland, including the subpoena of documents or records or the inspection of my dental practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under the Annotated Code of Maryland, Health Occupations Article, §4-315.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

**NOTARY SECTION**

State of \_\_\_\_\_, County of \_\_\_\_\_, Then personally appeared the above  
named \_\_\_\_\_, and signed and sworn to the truth of the foregoing statements in  
my presence.

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

**SEAL**

# Application for Dental Hygiene Licensure for Dental Hygienists Licensed in Another State

## CHECKLIST

*Please review prior to sending your application package to the Board.*

**Incomplete applications will be returned and will be subject to a \$50.00 application reprocessing fee.**

### PATH 1 AND PATH 2 CANDIDATES:

- ☐ 1. Is your application completed front and back?  
☐ Did you sign and have the application notarized?
- ☐ 2. Did you enclose the \$275 non-refundable fee in a check or money order made payable to the Maryland State Board of Dental Examiners?
- ☐ 3. Did you enclose one photo that is between 2x2-inches and 3x3-inches with the required notarized affidavit? Note that the photo will be affixed to your license. The photo must meet the following guidelines: taken within the last 2 years to reflect your current appearance; front view of full face from top of hair to shoulders; a natural expression; no hat or head covering that obscures the hair or hairline, unless worn daily for religious purposes; no sunglasses, headphones, wireless hands-free devices or similar items; no other individuals or distractions in the photo. Photos copied or digitally scanned from driver's licenses or other official documents are not acceptable. In addition, low quality vending machine or mobile phone photos are not acceptable. "Passport" photos are acceptable. Unacceptable photos will be returned and may delay the issuance of your license.
- ☐ 4. Did you **request** that an original National Board score card be forwarded to the Maryland State Board of Dental Examiners?  
**Board will obtain these scores upon receiving application.**  
  
You must contact the **National Board of Dental Examiners** at 211 E. Chicago Avenue, Suite 1846, Chicago, IL 60611 or **(312) 440-2678 or (800) 621-8099** and request that an **Original Score** be released to the Maryland State Board of Dental Examiners.
- ☐ 5. Did you attach proof of you passing an examination with a clinical component?
- ☐ 6. Did you **request** a certified ADEX/NERB examination report from Commissions on Dental Competency Assessments (CDCA) certifying that you have passed the Computer Simulated Clinical Examination (CSCE)? See [www.cdcaexams.org](http://www.cdcaexams.org)  
**Board will obtain these scores upon receiving application.**
- ☐ 7. Did you enclose certified proof of your dental hygiene education, such as a copy of a diploma or a letter from the school? *Please note that the original embossed school seal must be affixed to copies of transcripts and diplomas submitted to the Board.*
- ☐ 8. Did you enclose certified letters with the state seal affixed from each state in which you hold or have ever held a license verifying that the license is or was in good standing and that no disciplinary action has ever been taken against the license?
- ☐ 9. Did you attach a separate page identifying your employers for the 3 year period immediately preceding the date of your application beginning with your most recent employer. The document should include the following: (Please print or type) the name of your employer, name of your supervising dentist, street address, dates of employment, and the number of hours worked for each employer.
- ☐ 10. Did you enclose documentation of legal name change (i.e. marriage certificate, divorce decree or court documents) if the documents sent with the application are in another name?
- ☐ 11. Did you enclose the Maryland State Jurisprudence Examination and the notarized affidavit along with the \$50.00 non-refundable fee in a check or money order made payable to the Maryland State Board of Dental Examiners?

**PATH 1 CANDIDATES ONLY:**

- ☐ 1. Did you enclose certified examination scores from the ADEX/NERB?

**PATH 2 CANDIDATES ONLY:**

- ☐ 1. Did you enclose evidence that you have an active license to practice dental hygiene in a state other than Maryland?
- ☐ 2. Did you enclose evidence that you passed an examination with a clinical component as a requirement for licensure in another state?
- ☐ 3. Did you enclose an affidavit indicating that you have been actively practicing dental hygiene for at least 3 years, and that during the 3 year period preceding your application you have been actively engaged in practicing dental hygiene for at least 150 hours on average per year for a total of at least 450 hours.



## GUIDELINES FOR DENTAL HYGIENE LICENSURE FOR DENTAL HYGIENISTS LICENSED IN ANOTHER STATE

The Board shall not process a licensure application until each provision or requirement is met and each document is received. Please ensure that your application is complete before it is submitted.

The following criteria must be met by all candidates for licensure who are licensed in another state:

- a. Be of good moral character; and
- b. Be at least 18 years old; and
- c. Be a graduate of a school for dental hygiene that requires at least 2 years of education in an institution of higher education and is accredited by the American Dental Association Commission on Dental Accreditation and is approved by the Board; and
- d. Pass Part I of the National Board examination.

In addition to the above criteria, applicants must meet all criteria in either path 1 or all criteria in path 2:

**Path 1: You are a Path I candidate if you have passed the ADEX/NERB.**

- a. Pass the NERB or ADEX;
- b. Pass the NERB or ADEX Computer Simulated Clinical Examination (CSCE); and
- c. Pass the Maryland State Board of Dental Examiners Jurisprudence Examination on the dental laws and regulations in Maryland.

**OR**

**Path 2: You are a Path II candidate if you are licensed in a state other than Maryland, have not successfully passed the NERB or ADEX but you have met the Board's experience and other requirements.**

- a. Have a current dental hygiene license in a state other than Maryland;
- b. Pass an examination with a clinical component as a requirement for licensure in another state?
- c. Have been actively practicing dental hygiene for at least 3 years, and that for the 3 year period preceding your application have been actively engaged in practicing dental hygiene for at least 150 hours on average per year for a total of at least 450 hours.
- d. Pass the NERB or ADEX Computer Simulated Clinical Examination (CSCE) (website is [www.cdcaexams.org](http://www.cdcaexams.org)); and
- e. Pass the Maryland State Board of Dental Examiners Jurisprudence Examination on the dental laws and regulations of Maryland.

**Section I: Enclose the following with your application:**

**All candidates must submit the following:**

- *A \$275 non-refundable fee.* Additional fees may be levied by the Board for investigatory purposes.
- *A photograph* that meets the requirements contained in the Checklist with the following notarized statement: "The picture is a true photograph of me."
- *Original National Board score card.* You must contact the **National Board of Dental Examiners** at 211 E. Chicago Avenue, Suite 1846, Chicago, IL 60611 or **(312) 440-2678** or **(800) 621-8099** and request that an **Original Score Card** be forwarded to the Maryland State Board of Dental Examiners at the address below.
- *Certified proof of your dental education.* Acceptable proof includes a certified **copy** of a diploma, a letter from the dental school, or official transcripts. Please do not submit your original copy. **The document must contain the raised, embossed school seal certifying its authenticity. However, letters from educational institutions on original letterhead, bearing an original signature do not require a raised, embossed school seal.**
- *A certified letter with the state seal affixed from each state in which you hold or have ever held a license, verifying that the license is or was in good standing and that the applicant is not being investigated, does not have charges pending against the applicant's license, has not been disciplined, and has not been convicted or disciplined by a court of any state or country for an act that would be grounds for disciplinary action under Health Occupations Article, §4-315, Annotated Code of Maryland.*

- *Attach a separate page identifying your employers for the 3 year period immediately preceding the date of your application beginning with your most recent employer. The document should include the following: (Please print or type) name of your employer, name of your supervising dentist, street address, dates of employment, and the number of hours worked for each employer.*
- If applicable, *evidence of legal name change*, such as a marriage certificate or court documents.
- *Certified NERB or ADEX scores from the Commission on Dental Competency Assessments (CDCA) for the Computer Simulated Clinical Examination (CSCE). Contact **CDCA** at [www.cdcaexams.org](http://www.cdcaexams.org) to sit for the CSCE exam.*
- Clinical examination scores?
- *Maryland Jurisprudence Examination.* All applicants for licensure in Maryland must pass the Jurisprudence Examination on the Dental Laws and Regulations of this state with a score of at least 75%. It is an open book examination and may be found on the Board's website at [www.dhmf.state.md.us/dental](http://www.dhmf.state.md.us/dental). The examination cannot be taken on-line. You must download the examination, print a hard copy, and complete the examination. Send the completed examination, Affidavit, and \$50 examination fee to the Board's offices. Applicants may also take the examination at the Board's offices Monday through Friday, except holidays, between the hours of 9:00 AM and 4:00 PM. You will be scheduled for the examination after your completed application is reviewed. Please call to schedule the examination if you wish to take the examination at the Board's offices.

**In addition to the requirements in Section I, Path 1 candidates must submit:**

- a. Evidence that you have passed the NERB or ADEX;
- b. Evidence that you have passed NERB or ADEX Computer Simulated Clinical Examination (CSCE); and
- c. Evidence that you have passed the Maryland State Board of Dental Examiners Jurisprudence Examination on the dental laws and regulations in Maryland.

**In addition to the requirements in Section I, Path 2 candidates must submit:**

- a. Evidence that you have a current dental hygiene license in a state other than Maryland;
- b. Evidence that you have passed an examination with a clinical component as a requirement for licensure in another state;
- c. *A notarized statement* attesting to the fact that you have been actively practicing dental hygiene for at least 3 years, and that during the 3 year period preceding your application you have been actively engaged in practicing dental hygiene for at least 150 hours on average per year for a total of at least 450 hours. The statement must include the dates of practice, hours practiced, and location of practice.
- d. Evidence that you have passed the NERB or ADEX Computer Simulated Clinical Examination (CSCE); and
- e. Evidence that you have passed the Maryland State Board of Dental Examiners Jurisprudence Examination on the dental laws and regulations of Maryland.

**Incomplete applications will be returned and will be subject to a \$50.00 application reprocessing fee.**

**MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:**

Maryland State Board of Dental Examiners  
 The Benjamin Rush Building  
 Spring Grove Hospital Center  
 55 Wade Avenue  
 Catonsville, MD 21228  
 ATTN: Licensing Unit



# MARYLAND Department of Health

*Larry Hogan, Governor • Boyd K. Rutherford, Lt. Governor • Robert R. Neall, Secretary*

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## Maryland State Board of Dental Examiners

Spring Grove Hospital Center • Benjamin Rush Building  
55 Wade Avenue/Tulip Drive • Catonsville, Maryland 21228

PICTURE

This is a true photo of myself taken within the last 2 years to reflect my current appearance. In addition, the photograph complies with the photograph requirements contained in my application.

---

**Print Name**

---

**Applicant Signature**

---

**Date**

### **NOTARY SECTION**

State of \_\_\_\_\_, County of \_\_\_\_\_, Then personally appeared the above named \_\_\_\_\_, and signed and sworn to the truth of the foregoing statements in my presence.

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

**SEAL**

# MARYLAND STATE BOARD OF DENTAL EXAMINERS

SPRING GROVE HOSPITAL CENTER • BENJAMIN RUSH BUILDING  
55 WADE AVENUE/TULIP DRIVE • CATONSVILLE, MARYLAND 21228  
PHONE – 410-402-8511 • FAX – 410-402-8505  
[www.health.maryland.gov/dental](http://www.health.maryland.gov/dental)

## Jurisprudence Examination Affidavit

AFFIDAVIT of Applicant:

I, \_\_\_\_\_, do hereby certify under oath the following:

I understand that this is an open book examination and the only authorized sources of assistance for completing this examination are the Maryland Dental Practice Act and Regulations.

I have read the Maryland Dental Practice Act and Regulations in its entirety and have completed this examination without the aid or assistance of any individual or other unauthorized source.

I further understand that in accordance with Maryland Health Occupations Code Annotated, §4-315, the Board shall have the authority to refuse to grant a license or to revoke a license or to discipline a licensee upon a finding that licensee or applicant has knowingly made misleading, deceptive, untrue or fraudulent representations in the practice of dentistry or on any document connected therewith.

Witnessed my signature, the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Affiant

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

**SEAL**

# MARYLAND STATE BOARD OF DENTAL EXAMINERS

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[www.health.maryland.gov/dental](http://www.health.maryland.gov/dental)

**Please mail your completed test, affidavit and a check or a money order in the amount of \$50.00 (non-refundable) made payable to the Maryland State Board of Dental Examiners to the address listed above.**

Name\_\_\_\_\_

Date\_\_\_\_\_

Address\_\_\_\_\_

Social Security Number\_\_\_\_\_

\_\_\_\_\_

Telephone Number \_\_\_\_\_

\_\_\_\_\_

## DENTAL HYGIENE – JURISPRUDENCE EXAMINATION - 2020

The successful completion of this examination fulfills the Jurisprudence requirements for the Maryland State Board of Dental Examiners for Dental Hygienists. This examination is **open** book.

**SECTION ONE – TWO POINTS FOR EACH QUESTION. CIRCLE THOSE SERVICES WHICH ARE LEGALLY WITHIN THE SCOPE OF PRACTICE OF A DENTAL HYGIENIST IN MARYLAND.**

- |   |  |
|---|--|
| A. Place or remove an arch wire   | P. Construct athletic mouth guards on models     |
| B. Perform curettage  |  |
| C. Fabricate bleaching, fluoride and impression trays on models                     | Q. Remove a temporary restoration – intracoronal |
| D. Apply silver diamide   | R. Administer local anesthesia by infiltration   |
| E. Place and remove retraction cord   | S. Etch teeth                                    |
| F. Perform brush biopsy   | T. Perform a preliminary dental exam             |
| G. Administer nitrous oxide   | U. Remove sutures                                |
| H. Take alginate impressions for study models or diagnostic casts                   | V. Place an original periodontal dressing        |
| I. Apply bonding agent  | W. Prepare and fit stainless steel crowns        |
| J. Place or remove cemented or bonded orthodontic bands and attachments             | X. Apply pit and fissure sealants                |
| K. Perform vitality tests   | Y. Expose radiographs                            |
| L. Cement permanent crowns  |  |
| M. Adjust the occlusion of a natural tooth, restoration, or appliance – intraorally |  |
| N. Apply and remove a socket dressing   |  |
| O. Use high speed hand piece- intraorally   |  |

**SECTION TWO – FIVE POINTS FOR EACH QUESTION. CIRCLE LETTER NEXT TO THE CORRECT ANSWER. EACH QUESTION HAS ONE CORRECT ANSWER.**

- 1. Sexual misconduct of either a verbal or physical nature includes but is not limited to:**
  - a. Requesting sexual favors of a patient
  - b. Touching a patient in a sexual manner
  - c. Verbal conduct of a sexual nature while treating a patient
  - d. All of the above
  - e. Answers a. and b. only
  
- 2. Dental hygienists in the State of Maryland may perform dental hygiene services under general supervision in a private dental office with the permission of the supervising dentist if:**
  - a. The dental hygienist has at least 1,200 hours of dental hygiene clinical practice in direct patient care
  - b. Treatments authorized by the supervising dentist to be provided by the dental hygienist are rendered no later than 6 months from the date the patient was examined and evaluated by the supervising dentist
  - c. There is a written agreement between the supervising dentist and the dental hygienist that clearly sets forth the terms and conditions under which the dental hygienist may practice, including a statement that the dental hygienist may provide dental hygiene services without the supervising dentist on the premises
  - d. The number of unsupervised clinical hours worked by a supervised dental hygienist in any given calendar week is less than 50 percent of the dental hygienist's total hours
  - e. All of the above
  
- 3. Dental hygienists may be disciplined by the Maryland State Board of Dental Examiners for:**
  - a. Failing to display a copy of his/her license and renewal certificates
  - b. Willfully making or filing a false report or record in the practice of dental hygiene
  - c. Having been convicted of or having pled guilty or nolo contendere to a felony or to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or please set aside
  - d. All of the above

4. **In the office where you are employed as a dental hygienist, a dentist requests that you perform a procedure that is unlawful for a dental hygienist to perform in Maryland; however, you perform the requested procedure as directed by the dentist:**
- a. Your license to practice dental hygiene may be subject to disciplinary action by the Board
  - b. Your license to practice dental hygiene is not subject to disciplinary action by the Board since you performed the procedure as directed by a dentist
  - c. Only the dentist's license is subject to disciplinary action by the Board
  - d. Answers b. and c. only
  - e. All of the above
5. **Administration of Nitrous Oxide: A licensed dental hygienist in Maryland is permitted to administer nitrous oxide to dental patients under certain prescribed circumstances. Which of the following are true?**
- a. The dental hygienist must complete a 6-hour Board-approved course of instruction on administration of nitrous oxide through an accredited dental hygiene program
  - b. The dental hygienist must submit proof of having passed the Commission on Dental Competency Assessments Nitrous Oxide Examination for Dental Hygienists
  - c. The Dental Hygienist may not leave the operatory during administration or monitoring of the nitrous oxide except in emergency circumstances
  - d. The dentist need not be in the operatory, but must remain in the dental office during the administration and monitoring of nitrous oxide, and be in appropriate proximity to be summoned in the event of an emergency
  - e. All of the above are true
6. **An individual holding an expired general license to practice dental hygiene may apply for reinstatement if the individual:**
- a. Submits to the Board notarized affidavits, or other evidence satisfactory to the Board, that the applicant has actively practiced dental hygiene within the 3 years immediately preceding the date of application for reinstatement
  - b. Submits to the Board satisfactory proof of licensure and good standing from all states in which the applicant is currently licensed
  - c. Submits to the Board an application for reinstatement on a form provided by the Board
  - d. All of the above

7. **Dental hygienist in the State of Maryland may perform dental hygiene services under general supervision in a facility that has been granted a waiver of supervision if the dental hygienist:**
- a. Holds an active license to practice dental hygiene in Maryland
  - b. Holds a current certificate of Health Care Provider Proficiency in Cardiopulmonary Resuscitation
  - c. Have at least 2 years experience in direct patient care in the active clinical practice of dental hygiene
  - d. Holds a current certificate from a Board approved sponsor indicating successful completion of at least 8 hours duration on the treatment of the elderly and disabled in a dental health care setting
  - e. All of the above
  - f. Answers a., b., and c. only
8. **A dental hygienist who is recognized by the Board to administer local anesthesia may only do so under the supervision of a dentist who is physically present on the premises at the time of treatment.**
- a. True
  - b. False
9. **A licensee must complete \_\_\_\_\_ hours of continuing education in order to renew a dental hygiene license for a two-year period.**
- a. 12 hours
  - b. 15 hours
  - c. 25 hours
  - d. 30 hours
10. **The following intraoral functions may not be performed in the practice of dental hygiene.**
- a. Diagnosis
  - b. Cavity Repair
  - c. Tooth placement correction
  - d. Condensing, carving, or finishing any restoration
  - e. All of the above
  - f. Answers a. and b. only



# MARYLAND STATE BOARD OF DENTAL EXAMINERS

BENJAMIN RUSH BUILDING • SPRING GROVE HOSPITAL CENTER  
WADE AVENUE/TULIP DRIVE • BALTIMORE, MARYLAND 21228  
PHONE – 410-402-8510 • FAX – 410-402-8505  
[www.health.maryland.gov/dental](http://www.health.maryland.gov/dental)

PLEASE PRINT CAREFULLY. THIS WILL BE USED TO NOTIFY YOU OF YOUR RESULTS

## JURISPRUDENCE EXAMINATION SCORES

*FROM THE MARYLAND STATE BOARD OF DENTAL EXAMINERS*

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

SCORE: \_\_\_\_\_

☐ PASSED

☐ FAILED

# MARYLAND STATE BOARD OF DENTAL EXAMINERS

Spring Grove Hospital Center • Benjamin Rush Building • 55 Wade Avenue • Catonsville, Maryland 21228 • (410) 402-8510

## APPLICATION FOR RECOGNITION TO ADMINISTER LOCAL ANESTHESIA BY INFILTRATION AND INFERIOR ALVEOLAR NERVE BLOCK

Use this form if you seek recognition to administer local anesthesia by Infiltration and inferior alveolar nerve block by virtue of certification or other recognition in another state.

There is another form for those who are not recognized in another state.

### GENERAL INSTRUCTIONS

Complete all portions of the application. Enclose a \$50 (dollar) non-refundable check or money order made payable to the Maryland State Board of Dental Examiners. Enclose all necessary documents. Failure to do so may result in the return of the application.

#### Notice For Mailing List:

The information collected on this application form is collected for the purposes of the Board's functions under the Annotated Code of MD, Health Occupations Article, Title 4. Failure to provide the information may result in denial of your application. You have a right to inspect, amend, and request correction of this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law. Under the Maryland Public Information Act, Annotated Code of Maryland, General Provisions Article, §4-333, the Board may provide, for a fee, a list of licensees' names and addresses to professional associations and other entities. You may request in writing that your name be omitted from such lists.

### SECTION I – GENERAL INFORMATION

Name (Last, First, Middle Initial):	
Address of Record: (Street Address)	
City, State, Zip:	
MD Dental Hygiene License Number:	

**Note: If the address you have provided to the Board in this application differs from the address you have on file with the Board you must file a change of address form with the Board. The Board will not change the address it has on file if the address on this form differs from the address it already has on file. Failure to do so may result in your not receiving important information from the Board and may ultimately result in disciplinary action. Please keep an updated address on file with the Board at all times.**

G. Social Security Number:

<input type="text"/>	<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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(There is a statutory requirement that you disclose your social security number. It will be used for identification purposes only.)

H. Date of Birth:

<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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I. Home Phone Number:

<input type="text"/>	<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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J. Cell Phone Number:

<input type="text"/>	<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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K. Work Phone Number:

<input type="text"/>	<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**L. E-Mail Address:**

**M. Gender Identification:**

☐

Female

☐

Male

**H. Race/Ethnic Identification – Please check all that apply**

Are you of Hispanic or Latino origin? Yes ☐ No ☐

(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
2. ☐ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
3. ☐ Black or African American (A person having origins in any of the black racial groups of Africa.)
4. ☐ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
5. ☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

**J. Licensure in other states:**

List other states or jurisdictions in which you hold or have held a dental hygiene license.

State	License Number	Expiration Date

**K. Certification in other states:**

List other states or jurisdictions in which you hold or have held a certificate to administer local anesthesia.

State	Certificate Number	Expiration Date

## SECTION II - EDUCATION

A. School of Dental Hygiene (Name, City, State, Country): \_\_\_\_\_

B. Date of Graduation: \_\_\_\_\_ Degree Earned: \_\_\_\_\_

## SECTION III – RECOGNITION TO ADMINISTER LOCAL ANESTHESIA BY INFILTRATION AND INFERIOR ALVEOLAR NERVE BLOCK

A. What current state certification in local anesthesia are you using as a basis for certification in Maryland.

Name of state: \_\_\_\_\_

Date certification was issued: \_\_\_\_\_

Date of expiration: \_\_\_\_\_

B. Have you passed the American Board of Dental Examiners Inc. Local Anesthesia Examination for Dental Hygienists?

☐ Yes

☐ No

C. If you answered "Yes" to question B. provide the date on which you passed:

D. Have you successfully administered local anesthesia at least 25 times in the 2 year period immediately preceding the date of this application.

☐ Yes

☐ No

If you answered "Yes" to question D. attach a notarized affidavit to this application. You must sign and date the affidavit which must contain the following language: "I solemnly affirm under the penalties of perjury that the contents of the foregoing affidavit are true to the best of my knowledge, information, and belief." (A form Affidavit is attached).

## SECTION IV - CHARACTER AND FITNESS

**If you answer "YES" to any question(s) in Section V– Character and Fitness, attach a separate page with a complete explanation of each occasion. Each attachment must have your name in print, signature, and date.**

**YES NO**

☐☐

a. Has any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal entity denied your application for licensure, reinstatement, or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or non-judicial punishment? If you are under a Board Order or were ever under a Board Order in a state other than Maryland you must enclose a certified legible copy of the entire Order with this application.

☐☐

b. Have any investigations or charges been brought against you or are any currently pending in any jurisdiction, including Maryland, by any licensing or disciplinary board or any federal or state entity?

☐☐

c. Has your application for a dental hygiene license in any jurisdiction been withdrawn for any reason?

## Character and Fitness Questions – Contd.

**YES NO**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system?   |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system?  |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations?   |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Have you pled guilty, nolo contendere, had a conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?               |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Do you have criminal charges pending against you in any court of law, excluding minor traffic violations?  |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Do you have a physical condition that impairs your ability to practice dental hygiene?   |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Do you have a mental health condition that impairs your ability to practice dental hygiene?  |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Have the use of drugs and/or alcohol resulted in an impairment of your ability to practice dental hygiene?   |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Have you illegally used drugs?   |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal or state entity?  |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Have you been named as a defendant in a filing or settlement of a malpractice action?  |
| <input type="checkbox"/> | <input type="checkbox"/> | o. Has your employment been affected or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal entity for any disciplinary reasons or while under investigation for disciplinary reasons? |

The Well Being Committee assists dental hygienists and their families who are experiencing personal problems. The Committee has helped numerous dental hygienists over the years with problems such as stress, drug dependence, alcoholism, depression, medical problems, infectious diseases, neurological disorders and other illnesses that cause impairment. For more information please call 800-974-0068.

### Release and Certification:

I hereby affirm that I have read and followed the above instructions. I hereby certify that all information in this application is accurate and correct.

I agree that the Maryland State Board of Dental Examiners (the Board) may request any information necessary to process my application for recognition to administer local anesthesia by infiltration and inferior alveolar nerve block in Maryland from any person or agency, including but not limited to undergraduate and postgraduate program directors, individual dentists, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals, and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

I agree that I will fully cooperate with any request for information or with any investigation related to my practice of dental hygiene as a licensed dental hygienist in the State of Maryland.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under the Annotated Code of Maryland, Health Occupations §4-315.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

**NOTARY SECTION**

State of \_\_\_\_\_, County of \_\_\_\_\_, Then personally appeared the  
above named \_\_\_\_\_, and signed and sworn to the truth of the foregoing statements in  
my presence.

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

**SEAL**

## **Check List for Dental Hygienist Recognition to Administer Local Anesthesia by Infiltration and Inferior Alveolar Nerve Block by Virtue of Recognition in Another State**

**The Board may not process an application until each provision or requirement is met and each document is received. Please ensure that your application is complete before it is submitted.**

- ☐ 1. NOTARIZED APPLICATION: Completed application form accompanied by supporting documents. The licensure process could take up to a minimum of **30 days** after submission of a completed application. Plan your application time accordingly.
- ☐ 2. The \$50 non-refundable application fee payable by check or money order made out to the Maryland State Board of Dental Examiners (MSBDE).
- ☐ 3. Certified copy of your most recent certification to administer local anesthesia from the state Identified in your answer to question Section III A.
- ☐ 4. Grades from CDCA indicating that you passed the Local Anesthesia by Infiltration and Inferior Nerve Block.
- ☐ 5. Notarized affidavit indicating that you have successfully administered local anesthesia at least 25 times in the past 2-year period immediately preceding the date of this application. (Affidavit form attached)
- ☐ 6. Copy of court documents for any discrepancies of the applicant's name if documents submitted bear different name(s), [i.e. marriage certificate, divorce decree, legal name change].

### **MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:**

Maryland State Board of Dental Examiners  
Spring Grove Hospital Center  
Benjamin Rush Building  
55 Wade Avenue  
Catonsville, MD 21228  
ATTN: Local Anesthesia Recognition

# Affidavit

## Board Recognition to Administer Local Anesthesia by Infiltration and Inferior Alveolar Nerve Block by Virtue of Recognition in Another State

Complete This Affidavit Only If You Seek Recognition to Administer Local Anesthesia by Infiltration and Inferior Alveolar Nerve Block by Virtue of Recognition in Another State

I, \_\_\_\_\_, a registered dental hygienist in the State of Maryland do  
solemnly affirm under the penalties of perjury that I have successfully administered local anesthesia  
at least 25 times in the 2-year period immediately preceding the date of this application.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

### **NOTARY**

STATE OF \_\_\_\_\_

CITY/COUNTY OF \_\_\_\_\_

I HEREBY CERTIFY THAT on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, a Notary Public  
of the State of Maryland and the City/County aforesaid, personally appeared before me

\_\_\_\_\_ and made oath in due form of  
law that signing the foregoing Affidavit was his/her voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_



# MARYLAND STATE BOARD OF DENTAL EXAMINERS

Spring Grove Hospital Center • Benjamin Rush Building • 55 Wade Avenue • Catonsville, Maryland 21228 • (410) 402-8510

## DENTAL HYGIENIST RECOGNITION TO ADMINISTER NITROUS OXIDE BY RECOGNITION IN ANOTHER STATE

### GENERAL INSTRUCTIONS

Complete all portions of the application. Enclose a \$50 (dollar) non-refundable check or money order made payable to the Maryland State Board of Dental Examiners. Enclose all necessary documents. Failure to do so may result in the return of the application.

#### Notice For Mailing List:

The information collected on this application form is collected for the purposes of the Board's functions under the Annotated Code of MD, Health Occupations Article, Title 4. Failure to provide the information may result in denial of your application. You have a right to inspect, amend, and request correction of this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law. Under the Maryland Public Information Act, Annotated Code of Maryland, General Provisions Article, §4-333, the Board may provide, for a fee, a list of licensees' names and addresses to professional associations and other entities. You may request in writing that your name be omitted from such lists.

### SECTION I – GENERAL INFORMATION

Name (Last, First, Middle Initial):	
Address of Record: (Street Address)	
City, State, Zip:	
Maryland Dental Hygiene License Number:	

**Note:** If the address you have provided to the Board in this application differs from the address you have on file with the Board you must file a change of address form with the Board. The Board will not change the address it has on file if the address on this form differs from the address it already has on file. Failure to do so may result in your not receiving important information from the Board and may ultimately result in disciplinary action. Please keep an updated address on file with the Board at all times.

A. Social Security Number: --

(There is a statutory requirement that you disclose your social security number. It will be used for identification purposes only.)

B. Date of Birth: --

C. Home Phone Number: --

D. Cell Phone Number: --

E. Work Phone Number: --

F. E-Mail Address:

G. Gender Identification: ☐ Female ☐ Male

**H. Race/Ethnic Identification – Please check all that apply**

Are you of Hispanic or Latino origin? Yes ☐ No ☐  
(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
2. ☐ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
3. ☐ Black or African American (A person having origins in any of the black racial groups of Africa.)
4. ☐ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
5. ☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

**I. Licensure in other states:**

List other states or jurisdictions in which you hold or have held a dental hygiene license.

State	License Number	Expiration Date

**J. Certification in other states:**

List other states or jurisdictions in which you hold or have held a certificate to monitor a patient to whom nitrous oxide has been administered, a certificate to assist in the administration of nitrous oxide, or a certificate to administer nitrous oxide.

State	Certificate Number	Expiration Date

**SECTION II - EDUCATION**

A. School of Dental Hygiene (Name, City, State, Country): \_\_\_\_\_  
\_\_\_\_\_

B. Date of Graduation: \_\_\_\_\_ Degree Earned: \_\_\_\_\_

**SECTION III – RECOGNITION TO ADMINISTER NITROUS OXIDE IN MARYLAND**

A. Name of state in which you are currently certified or otherwise recognized to administer nitrous oxide: \_\_\_\_\_  
\_\_\_\_\_

Date certification was issued: \_\_\_\_\_

Date of expiration: \_\_\_\_\_

B. Have you passed the Commission on Dental Competency Assessments Nitrous Oxide Examination for Dental Hygienists?

☐ Yes ☐ No

- C. If you answered "Yes" to question B. provide the date on which you passed: \_\_\_\_\_
- D. Have you within the 2-year period immediately preceding the date of this application, in a state other than Maryland, successfully administered nitrous oxide to at least 10 dental patients without complications.
- ☐ Yes ☐ No

If you answered "Yes" to question D. attach a notarized affidavit to this application. You must sign and date the affidavit which must contain the following language: "I solemnly affirm under the penalties of perjury that the contents of the foregoing affidavit are true to the best of my knowledge, information, and belief." (A form Affidavit is attached).

#### SECTION IV - CHARACTER AND FITNESS

**If you answer "YES" to any question(s) in Section IV – Character and Fitness, attach a separate page with a complete explanation of each occasion. Each attachment must have your name in print, signature, and date.**

**YES NO**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Has any licensing or disciplinary board of any jurisdiction or any federal or state entity denied either your application for licensure, reinstatement, renewal, certification to monitor a patient to whom nitrous oxide has been administered, certification to assist in the administration of nitrous oxide, certification to administer nitrous oxide, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or non-judicial punishment? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Have any investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board or any federal or state entity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Has your application for a dental hygiene license, certification to monitor a patient to whom nitrous oxide has been administered, certification to assist in the administration of nitrous oxide, or certification to administer nitrous oxide been withdrawn in any state for any reason?   |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system?  |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Have you had any denial of application for privileges, failure to renew your privileges or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system?  |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations?  |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Have you pled guilty, nolo contendere, had a conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?  |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Are there any criminal charges against you in any court of law, excluding minor traffic violations?   |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Do you have a physical or mental condition that currently impairs your ability to practice dental hygiene?  |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?  |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Do you illegally use drugs?   |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal or state entity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Have you been named as a defendant in a filing or settlement of a malpractice action?   |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Has your employment been affected or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal or state entity for any disciplinary reasons or while under investigation for disciplinary reasons?   |

**Release and Certification:**

I hereby affirm that I have read and followed the above instructions. I hereby certify that all information in this application is accurate and correct.

I agree that the Maryland State Board of Dental Examiners (the Board) may request any information necessary to process my application for recognition to administer nitrous oxide in Maryland from any person or agency, including but not limited to undergraduate and postgraduate program directors, individual dentists, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals, and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

I agree that I will fully cooperate with any request for information or with any investigation related to my practice of dental hygiene as a licensed dental hygienist in the State of Maryland.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under the Annotated Code of Maryland, Health Occupations Article, §4-315.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

**NOTARY SECTION**

State of \_\_\_\_\_, County of \_\_\_\_\_, Then personally appeared the above named  
\_\_\_\_\_, and signed and sworn to the truth of the foregoing statements in my  
presence.

Notary Public: \_\_\_\_\_ My Commission Expires: \_\_\_\_\_

**SEAL**

## **Check List for Dental Hygienist Recognition to Administer Nitrous Oxide by Virtue of Recognition in Another State**

*Please review prior to sending your application package to the Board.*

- ☐ 1. Is your application completed front and back?
  - ☐ Did you sign and have the application notarized?
  
- ☐ 2. Did you enclose the \$50 non-refundable fee in a check or money order made payable to the Maryland State Board of Dental Examiners? (Note: The \$50 fee is waived if: a) you presently hold a recognition issued by this Board to "monitor" a patient to whom nitrous oxide has been administered by a dentist; b) you have taken and passed the Commission on Dental Competency Assessments Nitrous Oxide Examination for Dental Hygienists; c) you have filed an Affidavit with the Board indicating that you have, within the 2-year period immediately preceding the date of this application successfully administered nitrous oxide to at least 10 dental patients without complications; and d) you otherwise meet the requirements of the law. If you believe that you qualify for a fee waiver, please call the Board to confirm prior to submitting your application.
  
- ☐ 3. Did you enclose a certified copy of your most recent certification from the state of certification identified in your answer to Section III A. indicating that in a state other than Maryland you hold a certification or are otherwise recognized to administer nitrous oxide?
  
- ☐ 4. Did you enclose a certified examination score from the Commission on Dental Competency Assessments indicating that you passed the Commission on Dental Competency Assessments Nitrous Oxide Examination for Dental Hygienists?
  
- ☐ 5. Did you enclose a notarized affidavit indicating that you have within the 2-year period immediately preceding the date of this application, in a state other than Maryland, successfully administered nitrous oxide to at least 10 patients without complications?  
(Affidavit is attached.)
  
- ☐ 6. Did you include documentation of legal name change (i.e. marriage certificate) if the Documents sent with the application are in another name?

**APPLICATION FOR RECOGNITION TO ADMINISTER NITROUS OXIDE  
BY VIRTUE OF RECOGNITION IN ANOTHER STATE**

**The Board may not process an application until each provision or requirement is met and each document is received. Please ensure that your application is complete before it is submitted.**

**To apply for recognition, submit the Application and enclose the following with your application:**

- A \$50 non-refundable fee. (See note above for possible waiver of fee).
- A certified copy of your most recent certification from the state of certification identified in your answer to Section III A. indicating that in a state other than Maryland you hold a certification or are otherwise recognized to administer nitrous oxide.
- A certified examination score from the Commission on Dental Competency Assessments indicating that you passed the Commission on Dental Competency Assessments Nitrous Oxide Examination for Dental Hygienists.
- A notarized affidavit indicating that you have within the 2-year period immediately preceding the date of this application, in a state other than Maryland, **successfully administered nitrous** oxide to at least 10 dental Patients without complications. (Affidavit is attached.)
- If applicable, evidence of legal name change, such as a marriage certificate or court documents.

**MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:**

Maryland State Board of Dental Examiners  
Spring Grove Hospital Center  
Benjamin Rush Building  
55 Wade Avenue  
Catonsville, MD 21228  
ATTN: Administer Nitrous Oxide

# Affidavit

## Board Recognition to Administer Nitrous Oxide by Virtue of Recognition in Another State

### Complete This Affidavit Only If You Seek Recognition To Administer Nitrous Oxide by Virtue of Recognition in Another State

I, \_\_\_\_\_, a registered dental hygienist in

the State of Maryland do solemnly affirm under the penalties of perjury that within the 2-year period immediately proceeding the date of this application, in a state other than Maryland, I have successfully administered nitrous oxide to at least 10 dental patients without complications.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

### **NOTARY**

STATE OF \_\_\_\_\_ CITY/COUNTY OF \_\_\_\_\_

I HEREBY CERTIFY THAT on this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_, before me, a Notary Public of the State of Maryland and the City/County aforesaid, personally appeared before me \_\_\_\_\_ made oath in due form of

law that signing the foregoing Affidavit was his/her voluntary act and deed.

AS WITNESS my hand and Notary Seal.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_